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ABSTRACT

Intensive psychotherapy is principally limited to the middle class and the affluent population. Working class individuals utilize individual psychotherapeutic services at a low rate, and members of American ethnic groups (including "white ethnics") probably have even lower utilization rates. The reasons that therapists and ethnic clients avoid each other is that their values and cultural assumptions are often so different as to preclude an effective therapeutic relationship. The therapist assumes that a patient is there to work through his or her problems as an independent individual, motivated by the belief that all problems lend themselves to solutions. Ethnic patients, on the other hand, have often been socialized in subcultures in which the values of independence and individualism and the idea that people control their own lives are missing or irrelevant. Therapists must be able to take distance from their own world views and understand patients' ways of ordering their own psychological realities. If an ethnic patient's problems are due to conflict between his/her traditional social values and the values of dominant middle class America, the therapist should be able to help the patient to clarify the discrepancy and resolve the conflict. (Author/GC)

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CULTURAL FACTORS IN WORKING WITH PATIENTS

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Let me preface my remarks by first defining the term ethnic as it will be employed in this paper. Ethnic here is not limited to the designation of minority groups such as Blacks, Puerto Ricans and Chicanos as is usually the case. It also includes all members of American subcultural groups who have been socialized in homes where the dominant cultural forms were not the dominant American middle class ones. Therefore Italian Americans, Irish Americans, Armenian Americans, Jewish Americans and Boston Brahmims are considered in this sense to be ethnic.

It has long since been documented, first by Hollingshead and Redlich, and subsequently by the work of others, that intensive psychotherapy is an enterprise that is principally limited to the middle class and the affluent population of this country. Working class individuals constitute a disproportionately small segment of the population who avail themselves of individual psychotherapeutic services even when they are offered by community mental health clinics at a cost they can afford. Members of American ethnic groups, in turn, who constitute a significant portion of the working class population probably utilize therapeutic services at an even lower rate than their Anglo-Saxon Protestant White counterparts. It is also probably true

that members of certain ethnic groups who are upwardly mobile and who achieve a middle class status are less likely than native born middle class Americans, WASPS, to seek therapeutic help when they are troubled emotionally. While this is certainly not true of Jews who utilize therapeutic services at a disproportionately higher rate than the general population, it probably is true of Italians, Blacks and Irish middle class individuals.

It is not just a matter of therapists avoiding ethnic clients; it is an issue rather of a "gentleman's agreement" or rather a gentleperson's agreement that each will avoid the other. The thesis that I will elaborate is that this mutual avoidance is based on discordant existential or value orientation assumptions that constitute a cognitive, affective and conative chasm that has successfully separated therapists and clients in this country.

Effective therapeutic interventions are contingent on a system of shared meanings between therapist and client. These are rarely articulated by the therapist as such and almost never by the patient. Both operate from a common set of assumptions that pattern the therapeutic process itself. The therapist assumes that a patient is there to "work through" his or her problems for the purpose of attaining a better level of independent functioning some

time in the distant future and to be motivated in this endeavor by the belief that all problems lend themselves to solutions. The patient's problems are cause by di ordered interpersonal relationships, usually in childhood and the relationship with the therapist is expected to serve as a corrective emotional experience.

The ability to establish rapport with the patient is of course a consequence of the degree to which he or she is able to share these expectations of what the therapeutic enterprise is about. This will certainly be the case when the patient has been socialized in a White, middle class environment. This is because the assumptions which undergird the therapeutic enterprise are the same as those that pattern relationships among individuals in our society as a whole. American culture is based on a system of values, or value orientations which reflect the technologically advanced nature of our society. Americans are socialized to value individual achievement, independence in interpersonal relationships, to believe that all problems have solutions which hard work will eventually solve, that one must correspondingly resist immediate gratifications in the service of planning for rewards in some distant future and a view of human nature as being neither good nor evil but a product of the experiences an individual has undergone in the past.

These value orientations, as formulated by Florence Kluckhohn have

cognitive, affective and conative components and are functionally related to the adaptational demands of technologically advanced cultures like that of the United States. Middle class therapists have acquired these systematic modes of ordering the world in which they live and work. Their ethnic clients often have not. Ethnic patients have often been socialized in sub-cultures in which they have acquired value orientations that are markedly variant from those of their middle class therapists. They or their parents, or their grandparents emigrated from rural societies where a markedly variant set of value orientations were learned since the adaptational demands of agrarian cultures are by definition different. They would have acquired a "being" rather than a "doing" orientation as regards to the activity modality of experience. That is to say one does not aspire to achieve in societies where there is no where to go economically and socially. One looks instead to pleasures that can be enjoyed in the present such as the joy of good food and the joy of being together. Independence from others is also a functionally irrelevant orientation whereas interdependence with other family members is mandatory for survival. It also makes no sense to be future oriented; the realities of life are all occuring now, in the present and people feel subjugated to the vissicitudes of physical nature that they cannot control.

Difficulties are endured, and prayed to God about. And behavior of others is understood as a reflection of a good or a bad character.

These variant value orientations of ethnic individuals pattern their perceptions of the therapeutic process. The ethnic patient correspondingly expects a wholly different class of events to occur in the therapist's office. First of all, the concept of psychological causality based on a problem solving perceptual set would be outside the realm of his experience since it is based on a doing, mastery-over-nature and future time orientations foreign to individuals socialized in agrarian rural societies. He would, therefore not perceive psychological disturbance, such as anxiety or depression or difficulties in interpersonal relations as a "problem" that can be solved with the help of an expert. He is more likely to perceive affective disorders as having an organic basis - they "just happen" and he himself cannot be expected to exert any control over them (Being). He is the victim of an illness (Subjugated-to-Nature) as he might of appendicitis. It is his fate that this should happen to him. He expects the doctor (Lineality) to give him medicine to make it go away, now (Present). Interpersonal conflict is perceived as caused by the badness of the other person or persons. Since human nature is viewed as Good or Bad little can be done to change this fixed

state.

The mutual frustration between therapist and patient that can result from this incongruence of underlying assumptions or value orientations is of course not difficult to understand. Developing a therapeutic alliance with a patient of ethnic background is contingent on the therapist's ability to take distance from his own "world view" and to understand the patient's ways of ordering his psychological reality based on his own differing value orientations. He should also be in possession of conceptual tools with which to understand the acculturation process his patient is undergoing. In other words he should have some way of understanding where in the continuum from ethnic to core American values the patient is located at a particular point in time. Is the patient an individual who is struggling with problems of coping with the American social realities such as occupational advancement but who has not quite internalized the achievement values that could make this possible? Is he in-between the old world views internalized at home and the new world realities he is facing in the marketplace but unaware of the discrepancy between these opposing sets of values? If so, the focus of treatment would be on the clarification of this discrepancy and the alleviation of the "culture shock" that it entails. It would involve

helping the patient to acquire those specific behaviors that are necessary for effective coping in middle class society. The therapist, in other words, works toward the goal of facilitating the socialization of the patient to middle class norms since this is the direction he wants to go. The patient, on the other hand, may be an ethnic American, let us say Italian-American for example, whose life is socially and economically embedded within his sub-cultural group. The effort of the therapist to help him change his values in order to "adjust" better to American core society would not only be inappropriate it would be useless. The culturally sensitive therapist would focus instead on mobilizing social supports within the patient's extended family and utilize extant social supports within the Italian-American community in order to "strengthen" him, that is, to enhance effective psychological functioning. One cannot mobilize these supports unless one can understand the value system of the community he is trying to help the patient return to. Finally, let us, in another hypothetical case, suppose that an individual is struggling in a marital conflict situation with issues of power and control with his or her spouse. This conflict is caused by a discrepancy in values patterning interpersonal relationships internalized by each of them in their families during their

socialization. The man is a professional whose parents emigrated from Southern Europe and whose behavior in the home reflects the fact that he believes the man should make the decisions, and in fact his validation as a husband and father is contingent on his ability to do so. He retains this orientation, socialized in his ethnic home, in spite of the fact that he is viewed and indeed views himself as totally acculturated to American middle class society. She, from a mid-western family that originally emigrated to this country three generations earlier from Northern Europe is confused and enraged by his "authoritarianism." He attributes her anger toward him to her selfishness or some other character flaw (she is bad) and she retaliates with a similar characterization. If the therapist conceptualizes this marital conflict as an "acting out" of their individual intrapsychic conflict and ignores the cultural conflict that is manifest much will have been lost to the therapeutic work that needs to be done. The discrepancy in assumed value orientations that characterizes their interpersonal relationship needs to be dealt with if their relationship is to improve.

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